CENTENE Corporation

August 27, 2019

Via http://www.regulations.gov

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare and Medicaid Programs; Policy and Technical Changes for Years 2020 and 2021 (CMS 4185-P): RADV Provision

Dear Administrator Verma:

Centene Corporation (Centene) appreciates the opportunity to provide feedback on the RADV provisions of CMS' Proposed Rule*: Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021 (CMS 4185-P)*, published November 1, 2018. We appreciate CMS' efforts to provide additional information on the analysis it conducted related to the its RADV proposal and the extended comment deadline. Nonetheless, despite the additional information release, Centene still remains concerned about the underlying data validity, the possible negative beneficiary impacts, and the effect of major shifts in the RADV sampling methodology for CON14.

Founded in 1984, Centene Corporation (hereinafter "Centene") has established itself as a national leader in the healthcare services field with over 14 million members across the country. Centene provides health plans through Medicaid, Medicare, and the Health Insurance Marketplace and other health solutions through our specialty services companies. Centene covers 400,000 Medicare (including Special Needs Plan) beneficiaries across 19 states and 50,000 Medicare-Medicaid Plan (MMP) beneficiaries in six states. For over 30 years, Centene has been deeply committed to transforming the health of the community, one person at a time. We offer a comprehensive portfolio of innovative, flexible solutions that demonstrate our steadfast commitment to delivering results for our stakeholders: the federal government, state governments, members and their families, providers, and other healthcare and commercial organizations.

PROPOSAL COMMENTS

MEDICARE ADVANTAGE RISK ADJUSTMENT DATA VALIDATION PROVISIONS (II.C.2)

Starting with payment year 2011, CMS is planning to initiate extrapolation of sample findings to impose contract-level payment recoveries. In addition to the contract-level extrapolation methodology, CMS is proposing the possible use of a sub-cohort sample (e.g. for a particular HCC). Additionally, CMS is proposing not to include a

FFS error-rate adjustment based on an analysis showing that diagnoses errors in FFS claims do not lead to systematic payment errors in the MA program. In addition, CMS contends that the RADV audit process does not support any allowance for inherent errors in documentation.

Centene takes its responsibility to submit accurate diagnosis coding seriously as part of its CMS-HCC data submissions. We hope to work with CMS to productively develop a policy that maintains program integrity while also recognizing underlying data accuracy issues that occur in provider claims both in FFS and MA. While CMS engages in a productive dialogue with the broader industry, we wanted to highlight a few specific issues for comment and further clarification.

The FFS Adjuster

The analysis that CMS provided as its basis for not including a FFS adjuster is extremely outdated and additional details are needed from CMS to assess the appropriateness of the medical record review performed in the study. Without a more thorough understanding of the methodology, it is difficult to suggest specific modifications to the CMS-HCC methodology and/or RADV audits that would improve the correlation between HCC and expense—it is ultimately better to have a more accurate risk-adjustment methodology on the front end with an audit process that is reasoned and measured, rather than relying on audits to try to fix perceived payment methodology issues.

Related to extrapolation, we ask CMS to confirm that any extrapolation of overpayments would only be on the HCC portion of the member's premium (i.e. not include Demographic and other special status components). Centene would also like to seek clarification from CMS regarding its intentions with the RADV audit methodology going forward. Centene would appreciate a consistent approach over time; and would like to avoid being subject to multiple audit methodologies that may create different extrapolation and adjustment results (e.g. as the CON14 audit materially differs from CMS's 2012 guidance).

Centene also encourages CMS to consider the negative beneficiary impact the proposed policy may have; we are particularly concerned with the pricing dynamics that may occur when a contract that is the majority, or represents the entire book of MA business for an organization, is audited. Such organizations will not have the ability to spread costs across multiple contracts and thus may have to make more dramatic changes to their products and service areas to remain financially viable. Because of this, the policy as written could have the unintended consequence of driving toward further MA market consolidation among those organizations able to spread larger financial risks.

The CON14 RADV Methodology

It is unclear how recent sampling methodology changes implemented under CON14 RADV audits could be extrapolated for RADV recoveries. This methodology appears to be designed not to take a random sample of enrollees, but to maximize the possibility of finding those individuals with the highest probability of having coding errors. This methodology is inconsistent with the study CMS used as the basis of their proposal to not use a FFS adjuster and also does not appear to be the random sample or condition-specific sample approach proposed in the rule.

Due to the uncertainty around how the new CON14 sampling methodology could be extrapolated, we request that CMS provide details regarding the development of the regression model that was used to predict overpayments for each enrollee in the RADV-eligible population. We would particularly like more details on the data set used;

the model's independent variables, the predictive power of the model, and the most predictive terms of the regression.

We also request that CMS provide more information on the Tier II sampling approach including the basis for the 10% threshold and the reason for the particular inclusion of a diabetes diagnosis. We also note that the CON14 methodology selects contracts based on the highest count of members that fall into Tier II. This would seem to cause CMS to over-select larger contracts over smaller contracts. We seek CMS' rationale for selecting this approach.

RADV Appeals

CMS suggests using the appeals process outlined in § 422.311; given the possible extreme payment amounts that could result from the audits, we would encourage CMS to create additional flexibility for plans in terms of contesting legitimate disputes on medical record interpretation at all phases of the appeals process and allowing for supplementation of medical record information that could not be obtained at the time of the audit despite a plan's best efforts. We see these types of retrieval issues being especially concerning for audits that may go back to the 2014 payment year—where providers may no longer be in the same geography, retired, deceased or part of a different practice. To this end CMS should define the timing of RADV audits such that plans should expect notification, audits, and results within a set timeframe after the submission deadline.

****

Thank you for the opportunity to comment. If you have questions or need more information, please contact me at jdinesman@centene.com or 314.505.6739.

Sincerely,

Jonathan Dinesman
Senior Vice President, Government Relations